_____ **DATE OF INCIDENT:**_____

ENTITY RESPONSIBLE FOR AED

AED USE REPORT

To Be Filled Out Each Time an AED is Attached to a Patient

SUPERVISING PHYSICIAN:
Name: **David Silk, MD**
Address: **Saint Peter's Hospital, 2475 E Broadway, Helena, MT 59601**
Phone No: **444-2150**

Patient Age: _____ **Patient Sex:** ☐ **Male** ☐ **Female**

Location of Cardiac Arrest: _____

_____

Estimated Time of Cardiac Arrest: _____ **(use 24 hour time)**

CPR Initiated Prior to Application of AED: ☐ **YES** ☐ **NO**

Cardiac Arrest Witnessed? ☐ **YES** ☐ **NO**

Time First Shock Delivered: _____ **(use 24 hour time)**

Total Number of Shocks: _____

Pulse After Shocking: ☐ **YES** ☐ **NO** **If yes, was pulse sustained?** ☐ **YES** ☐ **NO**

Patient Transported: ☐ **YES** ☐ **NO**

If transported, to where and by who? _____

INSTRUCTIONS:

1. **Make a copy of this report and mail to: Department of Administration, General Services Division, Attn. Lou Antonick, PO Box 200110, Helena, MT. 59620-0110.**